



SCHIP Reauthorization and Financing: How Might California Fare?

Prepared for
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About the Foundation

The California HealthCare Foundation, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care.

Reauthorization of the State Children's Health Insurance Program (SCHIP) is a major health policy topic this year. During its 10 year history, SCHIP has played an integral role in facilitating access to health coverage for six million children nationally and helped sustain states' commitment to children's health coverage, even during difficult economic times.

California has the largest SCHIP program in the nation, known as the Healthy Families Program (HFP). In 2006 alone, the state spent more than \$1 billion in federal SCHIP funds; and over the past 10 years, California has spent more than \$5 billion to provide health insurance coverage for children with family incomes up to 250 percent of the Federal Poverty Level (FPL).¹ Federal contributions through SCHIP provide about 65 percent of the funding needed to operate HFP, which today covers roughly 800,000 children. Clearly, federal SCHIP funding plays a critical role in supporting California's health care system.

PURPOSE OF THIS ANALYSIS

This paper is part of the California HealthCare Foundation's body of work examining California's stake in the current SCHIP reauthorization debate.² It offers an overview of the SCHIP allotment formulas in two of the proposed bills that address SCHIP reauthorization and an analysis of what they might mean to California.

BACKGROUND

SCHIP was enacted as part of the Balanced Budget Act (BBA) of 1997 and provided states an additional opportunity to expand publicly-funded health care coverage for children. SCHIP offered a \$40 billion block grant of federal funding to states over ten years; there is no new funding for the program after September 30, 2007. SCHIP has been successful in decreasing the number of uninsured children nationally and in raising awareness about the importance of health insurance coverage. The estimated number of uninsured, low-income children nationwide decreased from nearly 23 percent in 1997 to 15 percent in 2003, despite a national economic recession that resulted in many families losing access to employer-based health insurance coverage.³ By 2005, the national uninsurance rate for children fell to 12 percent. California had a similar experience, with the number of uninsured children in the state falling from 21 percent in 1998 to 14 percent in 2005.⁴

The SCHIP statute (Title XXI of the Social Security Act) gives states significant flexibility in designing their programs. To implement SCHIP, states could choose to expand their existing Medicaid programs (called Medi-Cal in California), create a new children's health insurance program, or opt for a combination of both.⁵ California chose a combination approach. The state initiated a small coverage expansion under Medicaid by increasing Medi-Cal eligibility for children ages 6 to 18 from 85 to 100 percent of the Federal Poverty Level (FPL), and it created a separate program for children with incomes above Medi-Cal levels, known as the Healthy Families Program (HFP). HFP covers children with family incomes up to 250% of the FPL (\$43,380 for a family of three in

2007). California also uses SCHIP funds to enhance and support improvements to Medi-Cal, such as presumptive eligibility, that promote children's health insurance and specifically to support prenatal care.⁶ The Managed Risk Medical Insurance Board (MRMIB) oversees HFP and the Department of Health Services operates the Medi-Cal program.

In 2006, California spent its entire allotment of \$647 million, roughly 16 percent of the national allotment of SCHIP funds. This has not always been the case; a variety of factors inhibited the state from spending all of its SCHIP funds in the early years of the program. As a result, from 2001 to 2005, nearly \$1.5 billion of California's SCHIP funds were redistributed to other states. Today, HFP is serving more than 800,000 children and is spending at rates that exceed the state's allotment. In FY 2007, California will spend an estimated \$300 million over its allotment, making HFP a more than \$1 billion program, the largest in the nation.⁷

SCHIP: A FINANCING OVERVIEW

When SCHIP was authorized as part of the BBA of 1997, there was significant debate over the program's financing structure. Many wanted SCHIP to be an entitlement program, similar to Medicare and Medicaid, whereas eligible individuals are guaranteed coverage. However, as part of the compromise struck by a Democratic president and a Republican-controlled Congress, SCHIP funding is provided primarily through block grants, although states that decided to use SCHIP funds to expand their Medicaid programs also receive the SCHIP enhanced matching rate for children entitled to coverage through Medicaid.⁸

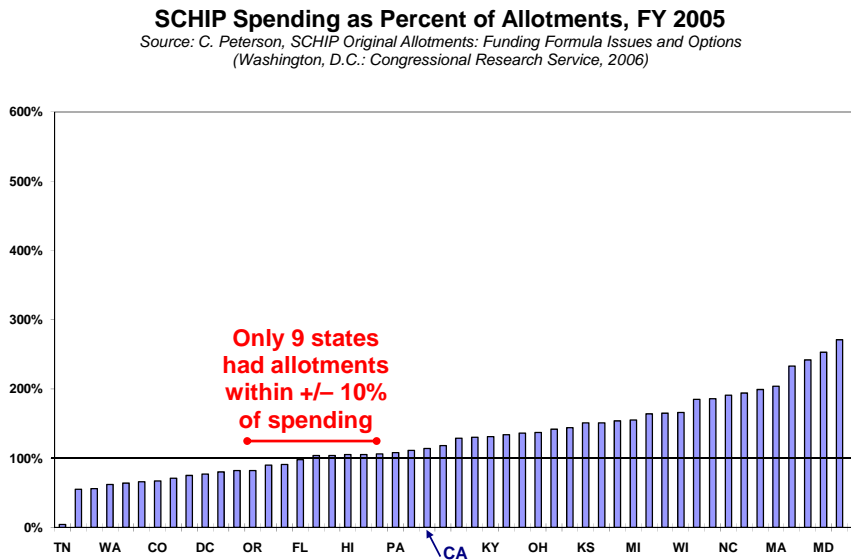
The basic financing structure of SCHIP brought with it several challenges for states.⁹ The SCHIP block grant formula has been criticized for being:

- *Unresponsive to economic cycles.* With a block grant, the total pool of resources available to states is independent of changes in the demand for coverage, which can make it difficult to address changing program needs. For example, during an economic downturn, states could see SCHIP enrollment spike, thereby putting enrolled children at risk if the state were to unexpectedly spend its entire allotment.¹⁰
- *Inconsistently funded over the ten years.* The funds available to states for SCHIP were not distributed equally over the ten year period. Instead, Congress allocated almost \$4.3 billion for each of the first four years of the program—1998 through 2001. In what is sometimes called the “CHIP Dip,” Congress then decreased the funding by more than \$1 billion to \$3.15 billion for each of the following three years, just at the point when state programs were maturing and enrollment was peaking. This was done solely to help ensure that the BBA could help balance the budget.¹¹
- *Misdirected in accounting for new program start-up.* The amount of the national allotment was higher in the first year than the tenth, failing to recognize that states would take time to ramp up the new programs and that enrollment and expenditures would grow over time. Again as a result of the overall budget-

- balancing formula, states received more money on the front end and are struggling to maintain enrollment as their programs have matured.
- *Inadequately targeted.* Initially, the SCHIP distribution formula relied primarily on calculating the number of low-income uninsured children in every state, using estimates generated by the Census Bureau's Current Population Survey. Over time, the formula was broadened to include a weighted average of the low-income uninsured estimate and the number of low-income children in the state (also using CPS data). However, the calculation has not reflected historical state spending patterns and enrollment levels. As SCHIP programs achieve the goal of insuring low-income children, uninsured rates decrease, thereby reducing state allotments. And while the CPS remains the best known and most comprehensive national survey of health insurance status, reliance on the state-specific data related to uninsured children has also proven problematic.¹²

As a result of these factors and other challenges, the federal SCHIP allotment formula led to a relatively poor distribution of funds across the states. Some states received significantly more than they could spend, while others received far too few funds to establish a significant program. In 2003, 10 states were spending more than twice their federal allotment for that year, while five states spent less than half of their allotment.¹³ Graph one illustrates the discrepancy between state allotments and state needs.

GRAPH ONE



Three-Year Allotments and the Redistribution Process

In recognition of the difficult challenge of accurately estimating states' financing needs for the new program, the SCHIP statute gave states three years to spend their SCHIP funds. Funds from annual allotments that were not spent after this period would then be "redistributed" using a formula that divided the total amount of unspent allotments among the states that had spent their full allotments during the three year period of availability. According to the statute, the redistributed funds are available for one year, after which point any remaining funds are to revert to the Treasury.

The rationale behind the redistribution process is that it increases the effectiveness of the SCHIP block grant by assuring that SCHIP funds eventually end up in the states where they will be used to cover children.¹⁴ In the early years, however, most states, including California, did not spend their full allotments because setting up separate SCHIP programs took longer than anticipated by Congress. It may have been unrealistic to expect that states would be able to achieve full enrollment within the first few years of program operation.

By the end of 2000, only 11 states had spent all of the federal SCHIP funds they received in fiscal year 1998.¹⁵ In 2000, Congress approved a measure to allow states to retain part of their unspent funds from the beginning of the program until September 30, 2002. Still, California lost \$1.46 billion in federal SCHIP funds that were ultimately reallocated to other states.¹⁶

Short-term Fixes

To address these shortcomings, Congress has acted six times in SCHIP's history to temporarily modify the program's state funding allocation rules. Congress has at various points allowed states to retain their allotments longer than three years, and has limited the amount redistributed in an effort to keep unspent money in the system. In 1999, Congress limited large annual changes in allotments. However, none of these temporary fixes has provided a permanent solution to the problem. In FY 2006, 38 states' (including California's) spending exceeded annual allotments;¹⁷ in FY 2007, 12 states exhausted their federal allotment and required relief from Congress. And Congressional efforts to address limitations in the CPS have been slow in developing.¹⁸ Inevitably changing political and policy priorities provide no guarantees for the program's financial stability.

ANALYSIS OF PROPOSED SCHIP FINANCING REFORMS

The purpose of this analysis is to understand the specific factors behind the proposed SCHIP financing structures being considered in the reauthorization discussion and how they might relate to California, the nation's largest SCHIP program in terms of spending and enrollment. This paper is not intended to be a comprehensive explanation of the formulas; rather, the goal is to provide an overview of the proposed changes to the SCHIP financing structure and to offer an explanation as to how these key elements could potentially impact California.

Simply put, the most important financial issue for SCHIP reauthorization is the magnitude of the new national allotments. A sufficiently large national allotment would remove a significant amount of the pressure to find a formula that is completely comparable for all states. For example, if the \$50 billion funding level called for under the recently passed budget resolution is achieved, California (and several other states) will likely have the federal financial resources needed to significantly expand coverage for children through HFP and Medi-Cal. The funding formula and its specific ability to target funds to California will become more important if the \$50 billion level is not met.

As of this writing, two major pieces of legislation have been proposed that would comprehensively address SCHIP reauthorization. Other bills have also been proposed, but these are the two being most prominently discussed.¹⁹

- *The Children's Health First Act* (H.R. 1535/S.895) is sponsored by Representative John D. Dingell (D-MI) and Senator Hillary Rodham Clinton (D-NY). Introduced in March 2007, the bill seems to represent a more global approach to achieving comprehensive children's health coverage and therefore includes sweeping principles in addition to some specific provisions related to SCHIP.
- *The CHIP Reauthorization Act of 2007* (S. 1224) is sponsored by Senators Jay Rockefeller (D-WV), Olympia Snowe (R-ME), and Edward Kennedy (D-MA). Introduced in April 2007, the bipartisan Rockefeller-Snowe bill is intended to address SCHIP reauthorization exclusively and may be used as the basis for the Senate "mark up" for SCHIP reauthorization.

Overview of the Proposed Allotment Formulas

The two bills approach the SCHIP financing structure quite differently, but agree on several of the key principles for reform and establishing state-specific allotments. Both would fundamentally benefit California by providing better targeting of funds and new areas of flexibility that will be helpful in advancing the state's goal of providing universal coverage for children.

The Children's Health First Act (Dingell-Clinton)

Dingell-Clinton envisions making health coverage available to all children, encouraging states to expand SCHIP coverage to families with incomes up to 400 percent of the FPL (nearly \$70,000 for a family of three in 2007). The bill provides a number of financial incentives for states to expand their programs as long as certain conditions — such as providing 12 months of continuous eligibility and eliminating barriers to enrollment — are met. The Dingell-Clinton proposal also targets the employer-sponsored insurance system as a vehicle toward coverage, giving states broader options for providing premium assistance so that families can buy in to, or stay enrolled in private coverage that is available to them.

Dingell-Clinton would replace the existing SCHIP block grant structure with what is essentially an entitlement for states, meaning that states would be assured of receiving as

many federal matching funds as needed to correspond with state spending levels. The proposal does not include an upper limit to the national SCHIP allotment. The Dingell-Clinton formula uses a bottom-up approach whereas the federal government would estimate how much each state needs to finance its SCHIP program in a given year, and then determine the amount of the national allotment. Beginning in 2008, the formula would initially be based on a state's SCHIP spending in FY 2007. For future years, the allotment amount would be indexed each year based on per capita increases in national health expenditures and the growth of the population of children in that state.

Beginning in FY 2010, SCHIP allotments would be re-based, that is, recalculated based on state spending in FY 2009 and then indexed by medical inflation and other population-based growth factors. The allotments would be re-based every two years thereafter. The key difference from current law is that if a state increases its SCHIP enrollment to levels higher than ordinary population growth, the financing would be made available and would continue to be open-ended within certain parameters. Under this bill, California would have the flexibility to implement the planned expansion to 300 percent of the FPL, as well as to enroll many of the children who are eligible for public coverage but have not enrolled with a guarantee that the federal matching funds would be available.

Dingell-Clinton indicates that any unspent funds would be divided proportionately among the states with the greatest need. (However, given the more open-ended nature of the proposal, it appears that the need for redistribution would be greatly diminished since the original allotments would be more closely determined by states' needs.)

The CHIP Reauthorization Act of 2007 (Rockefeller-Snowe)

The Rockefeller-Snowe proposal expands SCHIP funding and permits states to extend coverage to families with incomes up to 300 percent of the FPL (\$51,500 for a family of three in 2007). It maintains the existing block grant financing structure, but provides significant new federal resources for the program. The bill includes increased national allotment amounts totaling \$58.4 billion over five years (FY 2008-2012) and similarly revises the state-specific allotment formula.²⁰ The Rockefeller-Snowe formula relies on three factors in determining state allotments:

- "The Coverage Factor": State SCHIP spending in FY 2007²¹, indexed by the increase in national health expenditures and population growth;
- "The Uninsured Children Factor": The state's number of uninsured children with incomes below 200% of the FPL (based on the most recent CPS data, with additional funding for sample size improvements);
- A geographic cost adjustment that takes into account variation in health care costs across states (based on the health care wage index as used under current law).

Similar to the Dingell-Clinton bill, Rockefeller-Snowe would automatically update states' allotments every two years based on spending levels as well as health care inflation and population growth. This is intended to make initial allotments more reflective of states' needs and to lessen their reliance on redistributed funds for maintenance and/or expansion of SCHIP programs. This element will be important for California given the state's consistently increasing population, particularly among children.

To increase the stability of the allotment structure, the Rockefeller-Snowe proposal also provides a guarantee that states will receive (within the national capped allotment) at least the amount of their previous year's allotment (indexed for inflation) or the amount of their previous year's spending (indexed for inflation), whichever is lower, each year. An estimate released by Senator Rockefeller's office on April 27, 2007 provided preliminary projections of states' 2008 CHIP allotments based on S. 1224. The estimates project that California would receive nearly \$1.28 billion in federal funds for federal FY 2008, based on an estimated 835,000 low-income uninsured children in the state.²²

Rockefeller-Snowe includes a detailed proposal with respect to redistribution, acknowledging that the allotment formula is inherently fluid due to a variety of factors including fluctuating economies and states' outreach practices. The bill proposes that in states that do not spend their allotments after two years, any remaining funds will be added to the redistribution system to be re-invested in the overall program (the bill would strike the provision in the original SCHIP statute that requires any excess funds to eventually revert to the U.S. Treasury).

The proposal establishes a redistribution pool that would consist of a combination of a set-aside of up to 5 percent of the national allotment each year, and any allotment funds that are unspent after two years. The redistribution pool is expected to be significantly smaller than in the past, because of the improvements to the initial allotment formula and the periodic re-basing of states' allotments.²³

Rockefeller-Snowe also includes incentives that reward states for outreach efforts aimed at finding and enrolling the estimated 6 million children who are eligible for public health coverage programs but have not enrolled.²⁴ (See discussion of Enrollment Bonuses below).

ISSUES FOR CALIFORNIA

The remainder of this paper will provide an analysis of the financing elements of each proposed bill and consider how the proposals might affect California. (For a discussion of the more policy related provisions of these two bills, see "SCHIP: Opportunities for Improvement in the Upcoming Reauthorization Debate," the second paper in this series, available at www.chcf.org)

A few issues with the proposed financing structure of the bills have emerged with respect to California. Following is a brief description of each of the issues and an analysis of how California might be affected.

Block Grant vs. Entitlement

While neither formula proposes making SCHIP an individual entitlement program like Medicaid, the Dingell-Clinton formula would effectively guarantee that states will receive the funding they need to cover children. Under this formula, the federal government would reimburse states for all eligible children enrolled. This would

eliminate the pressure on states to limit program growth and would send a clear signal that SCHIP children are as important as seniors on Medicare or children in Medicaid. The only limit on funds to states is a cap in the growth of medical inflation.

Issues for California with the Block Grant Approach: California, like all states, would likely benefit from a state SCHIP entitlement because it would relieve state budget pressures. Since California has been overspending its allotment for several years, any change here (whether it is elimination of the national cap or offering financial adjustments) would help state policymakers fund the program. However, the Dingell-Clinton proposal will clearly be seen as a new and significant federal budget liability, limiting its prospects for passage. On the other hand, the Rockefeller-Snowe proposal, while maintaining the existing capped grant structure, proposes nearly \$60 billion in new SCHIP funding to be made available to the states over the next five years, which will also be beneficial to California. A capped grant structure holds much greater promise for passage in the current Congressional session.

Allotment Funds for the Coverage of Enrolled Children

As explained previously, both proposals rely on a determination of existing spending to establish future allotments. The fact that both bills base future state allotment amounts on existing spending levels for SCHIP is positive. For California, basing future allotments on FY 2007 spending will give the state more certainty to budget and plan for future expansions. In this process, a critical step for both proposed formulas is determining the base year spending level, as it will affect spending in all future years.

Under the Rockefeller-Snowe proposal, there are four possible methodologies that can be used to determine the base year funding level for FY 2008, with the state receiving the highest of all four calculations. This is referred to in the bill as “the coverage factor.” The first methodology is tied to actual FY 2007 spending and the second is based on the FY 2007 allotment amount. Options three and four rely on state-developed *projections* for SCHIP spending based on previous years’ expenditures as reported to the Secretary of HHS. A state’s allotment would be based on the highest spending projection provided by any of the four methods.

One concern is that there is no provision in the law for these projections to be audited by the Secretary or to reconcile or analyze the states’ estimates. As a result, some states may receive more funds than are actually needed. Since the Rockefeller-Snowe proposal maintains the capped allotment process, states could be put at a disadvantage, particularly if a state were planning to expand coverage. In particular, the amount of funding that is available for the second major element of the Rockefeller-Snowe allotment formula, called “the uninsured child factor,” (discussed in the next section) is determined after the coverage factor allotment has been established.

Therefore, if states project spending levels that are higher than what actually occurs, there will be fewer funds available when the uninsured child factor is calculated, which means that other states will receive lower allotments. The amount of money left over for the uninsured child factor is dependent upon on the amount of federal funds remaining after

the coverage factor has been determined. If an unreconciled approach is used, it will be important for the federal government to assure that sufficient funds will be made available to meet all states' funding needs. The Dingell-Clinton bill relies exclusively on actual state spending for the prior year and does not allow for state projections to be used, so the issue does not appear to apply.

Issues for California Related to the Base Year Allotment Formula: To help ensure that California receives sufficient funding to support the Healthy Families Program, the state has a clear interest in ensuring the accuracy of other states' allotments. The Rockefeller-Snowe formula appears to afford the opportunity for some states to receive allotments that may be larger than warranted.

Allotment Funds for the Coverage of Uninsured Children

Both formulas make an effort to account for coverage of children who are currently uninsured. Under Rockefeller-Snowe, the amount available for the uninsured child factor is uncertain because the amount of funding available for this adjustment would be based on how many dollars are left over after the coverage factor allotments are deducted from the national allotment. If an artificially high population growth factor is used in a given state, then the amount for the uninsured child factor would be reduced, therefore reducing the amount of money available to California and all other states. Given that there are proposals in the state to cover all children, the lack of predictability of this part of the allotment formula could make planning for such program expansions challenging.

In contrast, the Dingell-Clinton bill relies on state estimates of the number of uninsured children expected to be covered during the fiscal year. The initial allotment is determined based on that estimate, factored with an "enrollment bonus" that is equal to the state-specific per capita cost for covering an additional child above the initial estimate. At the end of the year, the state's enrollment is reconciled and states are reimbursed for any additional children covered above and beyond the initial allotment amount. This open-ended financing structure is more favorable to states and makes the uninsured child factor less important for budgeting purposes.

Issues for California Related to Allotment Funds for Uninsured Children: Any effort to cover all children will need to take into account the availability of supporting federal funds over time. It is likely that adoption of the Rockefeller-Snowe formula would mean that coverage of uninsured children under HFP will need to be phased in. The Clinton-Dingell bill offers greater funding certainty for states as compared to Rockefeller-Snowe. Careful planning will be needed to ensure that federal funding will be available for all children being enrolled in HFP

Adjustment for Medical Inflation

Once the base year allotments are established, both bills automatically increase the following year's allotment using a calculation of medical inflation (combined with other population-based growth factors). More specifically, both bills look at "per capita health care growth" projections of national health expenditures (NHE) as calculated by the Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS).

For the most part, California has successfully contained medical inflation in HFP spending. While some other state programs that use Title XXI funds, such as Access for Infants and Mothers (AIM), have relatively high rates of inflation and spending for pregnant women, HFP's cost growth has remained well below the national average.

Based on findings from earlier work for the California Health Care Foundation (CHCF) on spending projections for the HFP program, the chart below illustrates the weighted average in growth of inflation for Title XXI programs.²⁵ As shown in Table One, the inflation estimates from low to high are based on a range of factors related to specific Title XXI-funded programs versus the NHE growth estimates developed by the federal government.

Table 1

Annual Inflation Rate ²⁶ California Title XXI vs. NHE					
	FY2008	FY2009	FY2010	FY2011	FY2012
High	4.83%	4.85%	4.87%	4.97%	5.07%
Mid	4.16%	4.16%	4.16%	4.24%	4.30%
Low	3.48%	3.46%	3.45%	3.50%	3.54%
NHE	6.10%	6.40%	6.10%	6.00%	6.10%

Issues for California Related to the Medical Inflation Factor: California would almost certainly benefit from this adjustment. As the analysis shows, the NHE growth rates likely exceed those of California's programs.

Accounting for Child Population Growth

Both of the proposed bills include an adjustment to the states' annual allotments based on the growth in the state's overall population of children. The Dingell-Clinton proposal includes a straightforward adjustment based on estimates of state-specific growth in the child population.²⁷

Under the Rockefeller-Snowe proposal, the calculation would be based on the national (rather than a state-specific) average growth in the percentage of children, plus 1 percentage point. To determine the rate of growth in the child population, both formulas use the Current Population Survey. Although the CPS is the most widely used and comprehensive source of health coverage information, its limitations are widely acknowledged and have added to the inaccuracies of SCHIP allotments under current law.²⁸

In addition, there is a wide disparity across states with respect to growth in the population of children. Between 2000 and 2010, the United States growth rate for children under age 18 is estimated to be approximately 3 percent. However, using this average number hides the wide variation in projected growth rates across states. For example, several

states (including Michigan, West Virginia and New York) are actually expected to experience significant *decreases* in their populations of children. Conversely, other states (such as Nevada, North Carolina and Texas) will have even larger *increases* in their populations, making the use of the average even more problematic.²⁹ (See Appendix One.) Under the Rockefeller-Snowe formula, states with decreasing numbers of children will be rewarded.

By focusing on a national average calculation (CPS) instead of state-specific data, the Rockefeller-Snowe allotment levels may end up being too high or too low for many states.³⁰ Directing funds to states with decreasing numbers of children will reduce the funds available to states with higher rates of growth. States receiving funds that exceed their child population growth rate will have a greater opportunity to cover adults and other populations with those SCHIP funds.

Issues for California Related to the Growth Factor: Conflicting data makes it difficult to assess the impact of the growth factor. According to CPS' near term projections, California would likely benefit from using the national average for the growth factor rather than state-specific data. In an uncharacteristic shift in projections, the CPS has estimated that the national average growth in the number of children will be higher nationally than in California for the next several years.

Appendix Two presents CPS data, as well as the California Department of Finance's (DOF) projections for the number of children in California. DOF predicts a significantly higher rate of growth than CPS. If the DOF projections prove accurate, the state could be disadvantaged by using the national average.

Population Growth: Coverage of Pregnant Women

A separate but important issue for population growth is related to pregnant women. The SCHIP statute did not specifically authorize coverage of pregnant women, although CMS has granted approval for states to receive SCHIP funds for this group, and in some states pregnant women are a significant part of total enrollment.³¹ California is one of six states to use Title XXI funds to provide services to this group. But neither of the proposals specifically takes into account pregnant women (or coverage of parents) in calculating population growth. This issue also applies in states that have been using state-only funds to provide health coverage to uninsured immigrant children.

Issues for California Related to the Coverage of Pregnant Women: Enrollment of pregnant women in AIM and Medi-Cal has been faster than that of children. Congress could offer a similar population growth adjustment to account for increases in enrollment of pregnant women over time. This would help California in its continued efforts to ensure prenatal care and better birth outcomes.

Limiting Coverage to 200% of Poverty

Both bills propose an increase in SCHIP eligibility levels. The Rockefeller-Snowe proposal allows states to cover children up to 300% of the FPL and the Dingell-Clinton bill would expand coverage to 400% of the FPL. However, some in Congress and the

Bush Administration have expressed interest in limiting SCHIP funding to children with family incomes below 200% of the FPL. It is argued that the 200% of the FPL (\$34,340 for a family of three in 2007) is an appropriate level for public funding of health coverage. However, applying this standard uniformly does not take into account the wide variation in costs of living across the country. In California, 250 percent of the FPL may be a much more appropriate definition of “low-income,” as shown in the cost of living comparison at Appendix Three.

The federal government already recognizes that California has a high cost of living, as evidenced by the fact that the federal Office of Personnel Management (OPM) adjusts salaries to a higher level in California than other states. Of the top ten “Locality Pay Adjustments” offered by OPM, three are in California. The largest increase in pay for federal employees anywhere in the country is applied to those working in the Bay Area.³²

Issues for California Related to a 200% Cap: Limiting SCHIP funding to children with family incomes below 200% of the FPL could be very costly to California. As one of 14 states that cover children with incomes above 200% FPL, such a limitation could significantly reduce the federal funds that are available to the state. Even if the policy was to reduce the matching rate for children above 200% to the Medicaid level, as some have suggested, California would stand to lose a significant amount of federal funds.

“5%” Redistribution Set Aside

The Rockefeller-Snowe bill contains a number of provisions designed to prevent states from having funding shortfalls during the year. One such change is to the reallocation policy.³³ The proposal creates a “set aside” of 5 percent of the national allotment before the individual state allotments are calculated. After the two year period of availability, any remaining funds would be combined with the 5 percent set aside to form the redistribution pool for that year. This ensures a particular amount of money will be available to be redistributed to states that need additional funds.

Possible Issues for California related to the 5% Set Aside: The implications of this change to the redistribution formula for California is unclear. Under the proposed policy, California’s initial allotments will be 5 percent smaller than if the 5% set aside did not exist. Instead of holding these dollars in reserve, they might be more effectively used to fund SCHIP programs on the front end. At the same time, the proposed withholding constitutes a safety valve that might enable the federal government to direct funds to states mid-year if the need arises. If this policy were in place today, California would likely be a beneficiary given that the state has overspent its SCHIP allotment for the past several years. However, there is little quantitative data available at this point that would allow for a definitive conclusion.

Enrollment Bonuses

Both bills contain a financial bonus for meeting certain enrollment goals. Evidence over the years has indicated that SCHIP outreach efforts have been extremely effective in encouraging children to enroll in Medicaid as well.³⁴ Some states report two Medicaid

children for every SCHIP child identified. Like SCHIP, Medicaid works on a matching principle. In general, California receives one federal dollar for every dollar it spends on health care services provided through Medicaid.³⁵ The proposed enrollment bonuses are designed to increase that matching rate for spending on children's coverage, thereby rewarding states who meet the specified criteria. These bonuses are designed as incentive for states to renew or maintain existing outreach efforts and continue strategies for finding children who are eligible for Medicaid and SCHIP but have not enrolled.

Rockefeller-Snowe Enrollment Bonuses

The Rockefeller-Snowe proposal includes incentives for states to recommit to outreach efforts aimed at finding and enrolling the estimated 6 million children who are eligible for public health coverage programs but have not enrolled. The bill includes two possible bonuses:

- “For States Significantly Increasing Enrollment of Eligible Children”: Under Section 304 of the bill, it is possible for states to earn enhanced matching payments for year over year growth in Medicaid enrollment for children. States must have enrollment growth for children in Medicaid that exceeds an established benchmark level in order to earn the SCHIP-financed bonus. The benchmark is designed to grow over time, from roughly 1 percent in the first year up to 5 percent in the fifth year. This requires states to continuously increase enrollment rates in order to continue to receive the bonuses. The amount of the bonus is equal to the full percentage increase in enrollment over the prior year, as long as the benchmark level is met or exceeded.

Issues for California: The qualification requirements for the enrollment bonuses are very significant, and California seems unlikely to qualify at this point. For the 23 month period from January 2005 to November 2006, the number of Medi-Cal enrolled of children decreased by 1.44%.³⁶ However, the implementation of SB 437 (Escutia), the state's latest effort to enroll children in health insurance, may enable California to meet the proposed requirements. Other electronic gateways that may boost Medi-Cal enrollment are the SB 24 newborn gateway and the AB 1748 CHDP gateway fix. While implementation of SB 437 has been delayed, the Department of Health Services had estimated as many as 93,000 children could be added to Medi-Cal and HFP enrollment. If full implementation could occur in FY 2008, a bonus could be earned.

- “For States That Have Achieved At Least a High Performing Status”: It is also possible for states to receive a bonus based on the percentage of children without private insurance that are enrolled in some form of public insurance. In order to receive a bonus, states must have more than 90 percent of the children at or below 200% of the FPL without private insurance enrolled in public insurance.³⁷

Once the 90 percent threshold is met, states must fulfill another round of requirements. For the bonus to be made available, states must meet all four of the following conditions: 1) offer 12-month continuous eligibility; 2) have no waiting

list for Title XXI; 3) have no assets test for children; and 4) fulfill quality reporting requirements (to be determined). With the exception of the new reporting requirements, California currently meets all of these conditions.

Issue for California: The thresholds set by this provision are so high as to make it unlikely that California will receive a bonus. An unpublished analysis developed by the Center on Budget and Policy Priorities (CBPP) measures the impact of this provision on all states. They estimate that currently only one state, Vermont, would qualify for a bonus.³⁸ Assuming no other changes in the health care marketplace, approximately 540,000 currently uninsured children under 200% FPL would need to be enrolled in public coverage in order for California to qualify for the bonus.³⁹ According to the 2005 CHIS, 425,000 children in California were eligible for public health coverage programs but were not enrolled.

Dingell-Clinton Enrollment Bonuses

The approach in the Dingell-Clinton bill rewards process improvements, rather than specific outcomes. To earn a bonus, states must first implement 12 months continuous eligibility. States must then implement three of five “model outreach and enrollment processes” intended to facilitate the enrollment process, with choices including:

- Application Outreach Practices, which includes states holding annual enrollment campaigns in schools, facilitating year-around availability of applications, and the training of outreach staff to initially process applications.
- One-Step Application Process – including accepting a single application for multiple programs, such as Food Stamps (with similar income eligibility requirements); and implementing Express Lane eligibility
- Administrative Verification of Income – permitting self-declaration of income without requirement for unnecessary documentation.
- Simplified, consistent application form and process – including use of a joint Medicaid/SCHIP application and not requiring a face-to-face interview.
- Administrative renewal – meaning renewal for SCHIP can be done on an ex parte basis to the extent that the state has the needed information.
- Presumptive Eligibility – allowing children to access services while their application is being processed and eligibility is being determined.⁴⁰

Issue for California Related to the Enrollment Bonus: California already provides 12-month continuous eligibility, however it is not clear whether the state would be able to satisfy the requirement for utilization of three of the five possible options specified in the Dingell-Clinton proposal. While California seems to meet several elements of the other requirements, the legislative language is complex and makes a determination difficult. As noted previously, the state legislature has passed several proposals that would boost efforts in this area and many other enrollment streamlining initiatives, such as use of One-E-App, are well underway.

CONCLUSION

Although well-intentioned, the current financing system designed for SCHIP has been one of instability, unpredictability, and inadequate state targeting. Several spheres of influence were in play as the legislation was being debated and the goal of creating a straightforward, evenly funded health coverage program for low-income families was not always at the forefront. However, Congress has an opportunity this year to improve the system and renew its commitment to facilitating access to affordable, quality health care.

Both major SCHIP reauthorization proposals appear to do a better job of allocating resources to states in a manner that will be more responsive to state needs than the current system. There are important state-specific issues as outlined in this paper, as summarized in Appendix Four. The California-specific issues described in this paper are important, but they must be considered within a broader context. Both the allocation formulas and overall proposed funding levels under consideration would clearly provide a significant stepping stone along the path toward universal coverage for children in California and potentially across the nation.

APPENDIX ONE

State Population Projected Growth Rates 2000-2010

State	2000 Population Under 18	2010 Population Under 18	Population Growth Rate
United States	72,293,812	74,431,511	2.87%
Alabama	1,123,422	1,092,184	-2.86%
Alaska	190,717	183,983	-3.66%
Arizona	1,366,947	1,688,464	19.04%
Arkansas	680,369	702,656	3.17%
California	9,249,829	9,496,978	2.60%
Colorado	1,100,795	1,188,583	7.39%
Connecticut	841,688	814,008	-3.40%
Delaware	194,587	202,208	3.77%
District of Columbia	114,992	114,064	-0.81%
Florida	3,646,340	4,086,123	10.76%
Georgia	2,169,234	2,502,386	13.31%
Hawaii	295,767	316,263	6.48%
Idaho	369,030	400,237	7.80%
Illinois	3,245,451	3,196,906	-1.52%
Indiana	1,574,396	1,596,185	1.37%
Iowa	733,638	711,056	-3.18%
Kansas	712,993	698,996	-2.00%
Kentucky	994,818	1,002,307	0.75%
Louisiana	1,219,799	1,171,502	-4.12%
Maine	301,238	269,232	-11.89%
Maryland	1,356,172	1,406,294	3.56%
Massachusetts	1,500,064	1,483,853	-1.09%
Michigan	2,595,767	2,487,058	-4.37%
Minnesota	1,286,894	1,289,963	0.24%
Mississippi	775,187	759,450	-2.07%
Missouri	1,427,692	1,411,394	-1.15%
Montana	230,062	212,312	-8.36%
Nebraska	450,242	446,256	-0.89%
Nevada	511,799	665,085	23.05%
New Hampshire	309,562	304,164	-1.77%
New Jersey	2,087,558	2,088,224	0.03%
New Mexico	508,574	479,405	-6.08%
New York	4,690,107	4,420,876	-6.09%
North Carolina	1,964,047	2,268,838	13.43%
North Dakota	160,849	141,964	-13.30%
Ohio	2,888,339	2,744,431	-5.24%
Oklahoma	892,360	895,073	0.30%
Oregon	846,526	863,166	1.93%
Pennsylvania	2,922,221	2,747,595	-6.36%
Rhode Island	247,822	249,273	0.58%
South Carolina	1,009,641	1,036,349	2.58%

South Dakota	202,649	194,152	-4.38%
Tennessee	1,398,521	1,478,915	5.44%
Texas	5,886,759	6,785,408	13.24%
Utah	718,698	818,985	12.25%
Vermont	147,523	132,372	-11.45%
Virginia	1,738,262	1,880,184	7.55%
Washington	1,513,843	1,488,423	-1.71%
West Virginia	402,393	382,311	-5.25%
Wisconsin	1,368,756	1,319,144	-3.76%
Wyoming	128,873	116,273	-10.84%

U.S. Census Bureau, Population Division, Interim State Population Projections,
2005.

Internet Release Date: April 21, 2005

APPENDIX TWO

Child Population Demographic Comparison: CPS vs. CA DOF Projections

Data Set	National Projected Child Population - 19 & Under					Growth Rate	
	2000	2005	2010	2015	2020	2000-2010	2010-2020
CPS Data*							
Population	80,473,265	81,971,783	83,235,774	85,207,997	88,887,540		
Percent Increase		1.86%	1.54%	2.37%	4.32%	3.43%	6.79%

Data Set	California Projected Child Population - 19 & Under					Growth Rate	
	2000	2005	2010	2015	2020	2000-2010	2010-2020
CA DOF**							
Population	10,256,862	10,621,542	10,986,221	11,414,699	11,843,177		
Percent Increase		3.56%	3.43%	3.90%	3.75%	7.11%	7.80%
CPS Data*							
Population	10,234,571	10,532,377	10,679,916	10,876,591	11,474,523		
Percent Increase		2.91%	1.40%	1.84%	5.50%	4.35%	7.44%

Note: DOF growth rates for 2005 and 2015 are approximated. State projections are for 2000, 2010, and 2020 only.

***Current Population Survey (CPS) Data:**

File 2. Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex: July, 1 2004 to 2030 (<http://www.census.gov/population/www/projections/projectionsagesex.html>)

****State of California, Dept. of Finance (CA DOF) Data:**

Population Projections by Race/Ethnicity, Gender and Age for California and Its Counties 2000-2050, May 2004. (<http://www.dof.ca.gov/HTML/DEMOGRAP/ReportsPapers/Projections/P3/P3.asp>)

APPENDIX THREE

How does a 200% FPL Compare in California to Other States?

(200% FPL for a Family of Four in 2007 = \$41,300/year)

Large/Urban:

To maintain the same Standard of Living from San Francisco, CA to:	Atlanta, GA	Boston, MA	Washington DC
You need a salary of:	\$ 23,969.62	\$ 34,050.53	\$ 34,245.80
Groceries will cost:	32.359% less	14.614% less	23.591% less
Housing will cost:	65.579% less	37.178% less	21.400% less
Healthcare will cost:	15.397% less	6.998% more	11.742% less

Mid-Sized:

To maintain the same Standard of Living from Sacramento, CA to:	Des Moines, IA	Austin, TX	Detroit, MI
You need a salary of:	\$ 30,745.93	\$ 33,189.32	\$ 35,598.77
Groceries will cost:	33.151% less	26.833% less	20.515% less
Housing will cost:	44.523% less	42.473% less	25.432% less
Healthcare will cost:	17.254% less	10.479% less	10.93% less

Small/Rural:

To maintain the same Standard of Living from Bakersfield, CA to:	Tuscaloosa, AL	Asheville, NC	Boise, ID
You need a salary of:	\$ 37,109.04	\$ 38,061.53	\$ 36,385.15
Groceries will cost:	13.688% less	12.990% less	18.745% less
Housing will cost:	25.864% less	6.377% less	22.232% less
Healthcare will cost:	1.780% more	2.572% less	1.187% less

Source: CNN.com, downloaded April 2007.

<http://cgi.money.cnn.com/tools/costofliving/costofliving.html?step=form&x=25&y=6>

APPENDIX FOUR

KEY SCHIP FINANCING ISSUES FOR CALIFORNIA

Issue	Rockefeller-Snowe (S. 1224)	Dingell-Clinton (H.R. 1535)	Possible Impact on California
Eligibility Level	State option to expand SCHIP to 300% FPL (or 50 percentage points above existing coverage level).	State option to expand coverage to 400% FPL.	Both bills would significantly expand coverage options for California.
Calculation of Base Spending	Calculation of the coverage factor amount is based on the highest of : <ul style="list-style-type: none"> • FY 2007 spending; • FY 2007 allotment; • Spending projections for as reported to CMS under specified conditions. 	Base state allotments are determined by actual state spending.	The Rockefeller-Snowe bill's use of spending projections raises concerns about the accuracy of initial state allotments, which will then impact all future spending.
Uninsured Child Factor	Based on CPS estimates of uninsured children in the state (bill includes funding to improve CPS). This portion of the federal allotment would be determined after the coverage factor has been calculated.	Relies on state estimates of uninsured children expected to be covered during the FY, factored with an "enrollment bonus" equal to the per capita cost of covering children above the initial estimate.	The Dingell-Clinton bill offers greater funding certainty for states as compared to Rockefeller-Snowe, but both bills propose to significantly increase SCHIP funding.
Medical Inflation Factor	Annual allotments indexed by increases in national health expenditures (NHE) as	Same as Rockefeller-Snowe.	Both bills seem to offer a methodology that benefits California since the increases

Issue	Rockefeller-Snowe (S. 1224)	Dingell-Clinton (H.R. 1535)	Possible Impact on California
	calculated by the Office of the Actuary at CMS.		are based on national averages that California falls below.
Child Population Growth Factor	Allotments adjusted to account for general growth in the states' populations of children. Calculation based on the national average growth (estimated by CPS) in the percentage of children, plus 1 percentage point.	Allotments adjusted based on estimates of state-specific growth in the child population, also by relying on CPS estimates (rather than state generated estimates).	<p>Use of a national average growth rate by Rockefeller-Snowe will benefit states with growth that is below the national average. Due to conflicting projections for California, it is not clear if the state would benefit under this approach.</p> <p>This is less of a factor for Dingell-Clinton because states are held harmless for growth above the projected level.</p>
Enrollment Bonuses	<p>Opportunity for states to:</p> <ul style="list-style-type: none"> • “Enhanced” Medicaid matching rate when significant Medicaid enrollment growth is achieved. • High performance bonuses for demonstrating progress in reaching the uninsured and meeting a series of programmatic eligibility simplifications and quality assurance efforts. 	Rewards programmatic improvements such as 12 months continuous eligibility, enrollment simplification practices, outreach and marketing activities, presumptive eligibility and administrative renewals.	The legislative language is sometimes vague and complex making it difficult to determine whether California might meet the bonus requirements of one or both bills.

Issue	Rockefeller-Snowe (S. 1224)	Dingell-Clinton (H.R. 1535)	Possible Impact on California
Re-Basing	Beginning in FY 2010, allotments will be automatically updated (re-based) to reflect actual SCHIP spending from previous year.	Similar re-basing beginning in FY 2010.	The automatic re-basing of allotments will provide more stability for states and less reliance on redistributed funds over time.
5% Set Aside	Creates more stable redistribution “pool” made up of a 5% set aside of the national allotment, supplemented by allotment funds that remain unspent after 2 years.	No specific system proposed, but indicates any unspent funds would be divided proportionately among states with the greatest need.	<p>While Rockefeller-Snowe allotments will be smaller due to the 5% set aside, the provision would provide insurance against unexpected financing shortfalls.</p> <p>The Dingell-Clinton approach appears to greatly reduce reliance on a redistribution system.</p>

ENDNOTES

¹ California also receives federal SCHIP funds for children enrolled in the C-CHIP program (County Children's Health Insurance Program). This program expands coverage levels up to 300% of the FPL in Alameda, San Francisco, San Mateo, and Santa Clara counties.

² The first paper, "Funding California's SCHIP Coverage: What Will it Cost?," offered an analysis of California's SCHIP budget need over the next five years and is available at <http://www.chcf.org/documents/policy/FundingCaliforniasSCHIPCoverage.pdf>. The second paper, "SCHIP: Opportunities for Improvement in the Upcoming Reauthorization Debate," provides an overview of the programmatic issues that will likely arise and considered potential changes to SCHIP's eligibility and benefits rules.

³ John Holahan and Arunabh Ghosh, *The Economic Downturn and Changes in Health Insurance Coverage, 2000-2003*, The Urban Institute, September 2004; available at www.urban.org/UploadedPDF/411089_HealthInsCoverage.pdf. See also Cindy Mann, Jocelyn Guyer, and Joan Alker, *A Success Story: Closing the Insurance Gap for America's Children Through Medicaid and SCHIP*, Georgetown University Health Policy Institute, Center for Children and Families, Issue Brief, July 2005; available at <http://ccf.georgetown.edu/pdfs/success.pdf>.

⁴ Statehealthfacts.org based on the Census Bureau's Current Population Survey, March 2005 and 2006, downloaded January 19, 2006. The California Health Interview Survey data have a higher estimate for the number of uninsured.

⁵ Jennifer Ryan, "SCHIP: The Basics." March 27, 2007. Available at http://www.nhpf.org/pdfs_basics/Basics_SCHIP.pdf

⁶ The Access for Infants and Mothers Program (AIM) receives SCHIP funds for coverage of children up to 2 years old whose mothers are enrolled in AIM and have incomes between 200 and 250% of the FPL.

⁷ "State Children's Health Insurance Program Title XXI Federal Funds, Total Healthy Families Spending Projections (Children) Based on the November 2006 Estimate," California Managed Risk Medical Insurance Board, available at <http://www.mrmib.ca.gov/MRMIB/HFP/FedFundChart0611.pdf>

⁸ The SCHIP statute provides financing to states using an "enhanced" federal matching rate that is based on the Medicaid program's matching structure and more broadly on per capita income in each state. The SCHIP enhanced matching rates range from 65 percent in wealthier states (including California) to 87 percent in lower-income states. See Jennifer Ryan, "The Basics: SCHIP Financing", National Health Policy Forum, March 28, 2007, available at http://www.nhpf.org/pdfs_basics/Basics_SCHIPFinancing.pdf

⁹ The Alliance for Health Reform and Kaiser Commission on Medicaid and the Uninsured. *SCHIP: Let the Discussions Begin*. Web cast of Capitol Hill Briefing. February 9, 2007. Can be found at: http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2045

¹⁰ Historically, federal funds available through block grants tend to erode in real terms over time. K. Feingold, L. Sherry, and S. Schardin, "Block Grants: Historical Overview and Lessons Learned," Assessing the New Federalism Policy Brief A-63 (Washington: Urban Institute, April 2004).

¹¹ Chris L. Peterson, "SCHIP Original Allotments," Congressional Research Service, CRS Report RL33666. Available at <http://finance.senate.gov/hearings/testimony/2005test/072506cpattach1.pdf>

¹² Many states have raised concerns that the state-level CPS data have significant limitations, such as insufficient sample sizes, which results in over- or under-estimating the numbers of uninsured children. The CPS has also been criticized for unstable estimates from year to year and for not including straightforward questions about health insurance status.

¹³ Urban Institute tabulations of CMS expenditure data on SCHIP. K. Feingold, L. Wherry, and S. Schardin, "Block Grants: Historical Overview and Lessons Learned," Assessing the New Federalism Policy Brief A-63 (Washington: Urban Institute, April 2004).

¹⁴ Jocelyn Guyer, "Maximizing Child Health Coverage Depends on Establishing an Effective system for Reallocating Unspent SCHIP Funds." Center on Budget and Policy Priorities. Oct. 18, 2000, Available at <http://www.cbpp.org/10-18-00health.pdf>

¹⁵ Guyer, Jocelyn. "Maximizing Child Health Coverage," October 18, 2000.

¹⁶ Managed Risk Medical Insurance Board. SCHIP Title XXI Federal Funds Total Healthy Families Spending Projections based on the 2006 May Revision.

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- ¹⁷ Chris L. Peterson, "SCHIP Original Allotments," Congressional Research Service, CRS Report RL33666. April 18, 2006, <http://finance.senate.gov/hearings/testimony/2005test/072506cpattach1.pdf>
- ¹⁸ In 1999, Congress bolstered the sample size in the CPS survey to ameliorate criticism (P.L. 106-113); however results have been slow to come. The CPS estimate of uninsured, low-income children in California has a 13 percent margin of error. Jeanne M. Lambrew, "SCHIP: Past, Present and Future," The Commonwealth Fund, February 2007. Available at http://www.commonwealthfund.org/usr_doc/991_Lambrew_SCHIP_past_present_future.pdf. And, Chris L. Peterson, "SCHIP Original Allotments," Congressional Research Service, CRS Report RL33666, Table 7. April 18, 2006. Estimates are for 2003-2005.
- ¹⁹ Other bills have also been introduced that address SCHIP reauthorization, such as H.R. 2147, sponsored by Rep. Rahm Emmanuel (D-IL) and H.R. 1013, sponsored by Rep. Michael Burgess (R-TX).
- ²⁰ S. 1224, section 101, available at www.senate.gov/rockefeller
- ²¹ Or another calculation as specified in section 201 of the bill.
- ²² It should be noted that the state's calculations may differ from the projections offered by Senator Rockefeller, but the estimate is helpful for purposes of understand the potential impact of the revised allotment formula. Office of Senator Jay Rockefeller, "Press Release Announcing Projections of States' 2008 CHIP Allotments under S. 1224," May 4, 2007, available at <http://www.senate.gov/~rockefeller/news/CHIP%20Reauthorization%20Act%202008%20State-By-State%20Projections.doc>
- ²³ "Rockefeller-Snowe-Kennedy CHIP Reauthorization Act of 2007 (S. 1224) Key Elements of the Financing Structure," April 27, 2007.
- ²⁴ For a full summary of the bill, see Senators John D. Rockefeller IV and Olympia Snowe, "Summary of the Children's Health Insurance Program (CHIP) Reauthorization Act of 2007," April 26, 2007. Available at <http://www.senate.gov/~rockefeller/news/Final%20Rockefeller-Snowe%20CHIP%20Reauthorization%20Bill%20Summary.doc>
- ²⁵ Peter Harbage, Lisa Chan and Clara Evans, "Funding California's SCHIP Coverage: What Will it Cost?" California HealthCare Foundation, May 2007, available at <http://www.chcf.org/documents/policy/FundingCaliforniasSCHIPCoverage.pdf>
- ²⁶ Harbage et al, "Funding California's SCHIP Coverage"
- ²⁷ A floor would prevent the growth rate from being negative.
- ²⁸ As noted earlier, the CPS is not ideally suited for measuring major trends at the state level. Although the sample size has been improved over the last few years, states have continued to raise concerns about the CPS's accuracy in terms of estimating numbers of low-income uninsured children. North Carolina, for example, has consistently had more low-income children enrolled in the SCHIP program than CPS estimates indicated were eligible. As a result, the state has had a shortfall each year and was forced to take steps to control enrollment growth.
- ²⁹ U.S. Census Bureau, Population Division, "Interim State Population Projections," 2005. Internet release date April 21, 2005. Available at www.census.gov.
- ³⁰ This is similar to that used under Clinton-Dingell. However, since states are ultimately held harmless for any additional children enrolled above the population growth rate, this factor is less important than under the Rockefeller-Snowe proposal.
- ³¹ Government Accountability Office, "State's SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization," GAO-07-558T, March 1, 2007, 24. Available at www.gao.gov/cgi-bin/getrpt?GAO-07-558T
- ³² 2007 OPM Pay Tables, found at: <http://www.opm.gov/oca/07tables/pdf/saltbl.pdf>
- ³³ S. 1224, Section 203: Establishment of a Timely and Responsive Distribution Process.
- ³⁴ Mathematica Policy Research, "The Santa Clara Healthy Kids Program: Impacts on Children's Medical Vision and Dental Care," July 2005. <http://www.mathematica-mpr.com/publications/PDFs/santaclara.pdf>
- ³⁵ California receives a 50% Medicaid matching rate, known as the Federal Medical Assistance Percentage or FMAP. The state's matching rate for SCHIP is 65%. Supplemental federal payments to Medicaid effectively increase the matching rate.
- ³⁶ Unpublished Analysis, California Department of Health Services, Fiscal Forecasting.
- ³⁷ There is a drafting error in the bill. Having checked with the author's office, the interpretation given here represents the intent of the language.

³⁸ Unpublished Analysis, Edwin Park and Matthew Broaddus, Center for Budget and Policy Priorities.

³⁹ The formula used to determine the 90% level has a number of moving parts. It is possible for a state to qualify for a bonus if more children are covered under private insurance or a mix of public and private insurance. For simplicity, the example here focuses on 100% of new enrollment being in public programs.

⁴⁰ HR 1535, section 121, p27-29.